Arizona Medical Board

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FINAL MINUTES FOR ONE DAY MEETING
Held on May 18, 2007
9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

William R. Martin III, M.D., Chair
Douglas D. Lee, M.D., Vice Chair
Dona Pardo, Ph.D., R.N., Secretary
Patrick N. Connell, M.D.
Dan Eckstrom
Robert P. Goldfarb, M.D., F.A.C.S.
Patricia Griffen
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Paul M. Petelin Sr., M.D.
Germaine Proulx
Amy J. Schneider, M.D., F.A.C.O.G.

Call to Order
The meeting was called to order at 8:00 a.m.

Roll Call
The following Board Members were present: William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Members were absent: Dan Eckstrom and Douglas D. Lee, M.D.

Call to the Public
Statements issued during the Call to Public are listed below the case referenced.

Executive Director's Report — Timothy C. Miller, J.D.

Discussion of Attorney General's Office Contracts

Timothy Miller, J.D., Executive Director, presented to the Board options for dealing with a backlog of cases awaiting Formal Hearing that were referred to the Attorney General's Office (AGO). This issue was initially discussed during the Board's regularly scheduled February 2007 meeting. However, there are now 49 licensees who are waiting for their cases to be heard before the Office of Administrative Hearings (OAH) and the AGO is on average completing 10 cases per year. Mr. Miller presented the Board with options and recommendations for ways the backlog could be reduced while being mindful of the impact on the agency and the AGO. The first option would be to have Board Counsel from the Solicitor General's office (SGO) assume responsibility for judicial review actions (JRA) and appeals. He noted that Ms. Cassetta has experience with appeals and this would help relieve the workload for the Litigators at the AGO so that they could spend more time on formal hearings. This change would need to be implemented in a way that would not affect Ms. Cassetta's services to the Board. Another option would be to redirect resources from the SGO to the Licensing and Enforcement Section (LES) so that an additional litigator could be hired. Another option would be to use those resources to hire outside counsel. Another option would be to implement a hybrid of these options. A final option proposed was to maintain the status quo and require the litigators reduce the case backlog. With this option, the process would

continue as is another year with no additional services provided. Mr. Miller stated he brought this issue before the Board for their input and direction regarding continuation of the Board's legal services.

Robert P. Goldfarb, M.D., asked if the Board had paid their contract in full or were there residual funds since the AGO had not been fully staffed, yet moneys were transferred for legal services. Mr. Miller replied that the Board will receive a refund for services not used, but it would not be available to use. Rather, it would be deposited in the Board's reserve fund and a special appropriation would be required in order to obtain the funds. Dr. Goldfarb expressed his concerns stating that when he joined the Board he felt there was a great deal of litigation support; however, he has not felt the same level of support during the past year and a half. He stated it was not the fault of the Assistant Attorney Generals (AAGs); however, the Board needs to come up with a realistic plan to reduce the case backlog and keep the services of the SGO as Ms. Cassetta has rendered a very valuable service to the Board. Dr. Goldfarb stated he saw two options, one being to hire an additional attorney at the AGO, but it would take three months to train a new attorney. The second option would be to hire an outside law firm since they would have the expertise to help reduce the backlog. Dr. Goldfarb recommended hiring outside legal counsel and maintaining the Board's current relationship with the AGO. Dr. Goldfarb was happy Ms. Cassetta agreed to handle the appellate work, but was afraid this was a small portion of the workload.

Patrick N. Connell, M.D., agreed with Dr. Goldfarb. He stated that when he came to the Board almost ten years ago, the same issues with the AG existed as there was a backlog of 37 cases waiting Formal Hearing. There were several meetings with the then-AG that were somewhat contentious and the AG was opposed to hiring outside counsel. The Board proceeded in retaining outside counsel for assistance and the backlog was reduced significantly. Dr. Connell agreed with Dr. Goldfarb that the Board needs to obtain outside counsel until the issue is resolved. He stated there are physicians who have been waiting 3-4 years for their case to go to formal hearing, which is a significant issue because the Board has an obligation to protect the public.

Dr. Krishna stated that the same problem arose when he was Chair so he is concerned and suggested the Chair speak to the AG to express the Board's concern and request their help in resolving this issue. He stated that even if the Board does relieve some burden by having SGO take over some of the duties currently being performed by LES it would not make a significant impact. Dr. Krishna does not want the Board to sever ties with the AGO and should retain the services provided by SGO. He stated that the solution may be to address the Legislature and request funding assistance.

Lorraine Mackstaller, M.D. stated she hoped that Ms. Cassetta would remain with the Board and commented that she provides strong legal advice. Paul M. Petelin, Sr., M.D., asked if the Board had available funds to outside legal assistance, if needed. Mr. Miller advised that the funds are not available without a taking them from other sources or from a special allocation from the Legislature, which would be difficult at this stage in the legislative session.

Dona Pardo, Ph.D., R.N. that that as one of the more senior Board Members she remembered what it was like before the Board retained Ms. Cassetta's services and did not want to return to that, and therefore the Board should think of more viable options.

Dean Brekke, Assistant Attorney General, from LES stated that from the period January 2000 to 2004, staffing was consistent in the AGO and during that time they completed 123 cases either by Consent Agreements or hearing and returning cases to the Board for non-disciplinary resolution. Since March 2005, the AGO has been experiencing staffing changes. He noted that for a year at least one of the three attorneys was gone and on two occasions there was a 5-month gap between one attorney leaving and another being hired. Mr. Brekke stated it takes 3-6 months for an attorney to learn the administrative procedures and the technical aspects of the Board. He stated that Anne Froedge, Assistant Attorney General, has just completed her first full year in LES and Emma Mamaluy, Assistant Attorney General, has already finished 3 cases since starting in January of 2006. He stated that this is the first time in two years that they have 3 experienced litigators and are now capable of resolving the backlog. In addition to handling formal hearings, Mr. Brekke stated that the litigators handle JRAs, provide legal advice to the Staff Investigational Review Committee (SIRC) and the Evaluation Review Committee (ERC), and respond to Motions for Rehearing/Review and subpoenas. He assured the Board that with the three attorneys they will make a significant dent in the backlog of cases waiting for Formal Hearings. Mr. Brekke noted that when the Board last hired outside counsel it spent $220,000 over a two year period and twelve cases were completed. With $220,000 over a two year period (including employee related expenses etc.) LES could hire a five-year experienced attorney. Mr. Brekke informed the Board another significant portion of the litigators' time is spent on summary action cases. In the last two years 600 hours of his time was spent on summary action cases.

Dr. Krishna stated that the Board appreciates the services from the AGO and thinks that the Board has a tremendous advantage in having an Executive Director with a legal background such as Mr. Miller. He suggested the Chairman work with Mr. Miller to determine how to resolve the case backlog issue. Dr. Goldfarb noted the Board appreciated LES's work and that they need to keep it up and they need support. Therefore, it is important to find funding for the Board to retain outside legal counsel and that the Board has to be prepared for an increase in the number of cases on appeal or being sent to formal hearing over the next two

years. William R. Martin, III, M.D., Chair, summed up what he heard the Board members saying: it was paramount to retain the SGO services of Ms. Cassetta because she serves a valuable role that must be maintained. Dr. Martin noted that the legal world was changing and becoming more complex. The past budget and attorney staffing levels may have been sufficient in the past, but it is not enough for the current needs and certainly will not be enough for the future. He stated that the Board needs to find ways to obtain additional funding and build it into the budget to increase its legal representation.

Ms. Cassetta noted that working in the public sector involves certain financial sacrifices that she has been happy to make because she enjoys the work she does for the Board and feels it makes a difference to the public. Ms. Cassetta thanked the Board for their support because it reinforces the choice she has made to work in the public sector.

Chair's Report — William R. Martin, III, M.D.

William R. Martin, III, M.D., Chair, stated that Drs. Goldfarb, Pardo, Krishna and he recently represented the Board at the Federation of State Medical Boards (FSMB). Dr. Krishna described the issue of license portability that was addressed at the FSMB and noted the Board should be prepared for license portability by reviewing their current requirements for licensing. Dr. Krishna suggested that the Board's requirements for licensure should be comparable with the majority of other states. Mr. Miller, Executive Director, stated that he was invited to Washington D.C. by the National Governor's Association, e-Health Taskforce to comment on the issue of license portability. The primary focus was upon licensing fees and Mr. Miller felt the issue was extremely timely as it will become reality sooner rather than later. Dr. Martin stated he hopes the Board can respond proactively. Dr. Martin appreciated all input from the Board Members and Staff. Dr. Martin stated that Subcommittees have recently been formulated and, having considered the comments made by the Board Members during the April 2007 Board Meeting, the Board will be going forward with only two Subcommittees at this time.

OTHER BUSINESS (Non-Time Specific)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0346C	AMB	VEERASHEKARAPPA MOODABAGILU, M.D.	26014	Accept Proposed Consent Agreement for a Letter of Reprimand for failure to address new onset of neurological deficits.

Ram R. Krishna, M.D. recused himself from this case. Vicki Johansen, Case Manager, summarized the case for the Board. Patrick N. Connell, M.D. stated that he reviewed the case file and that the Consent Agreement appropriately resolved this case.

MOTION: Patrick N. Connell, M.D. moved to accept the Proposed Consent Agreement for a Letter of Reprimand for failure to address new onset of neurological deficits.
SECONDED: Robert P. Goldfarb, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.
Absent: Dan Eckstrom, Douglas D. Lee, M.D., and Lorraine L. Mackstaller, M.D.
VOTE: 8-yay, 0-nay, 0-abstain, 3-absent, 1-recuse.
MOTION PASSED.

OTHER BUSINESS (Time Specific)

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-07-0309A	AMB	THOMAS GRADE, M.D.	10424	Summary Suspension of license.

Thomas Grade, M.D., was not present during the consideration of this case. Kathleen Muller, Monitored Aftercare Program Manager, summarized the case for the Board. On April 26, 2007, Board Staff received a confidential report that Dr. Grade was arrested on April 25, 2007 for Assault and Assault Domestic Violence and that he was intoxicated at the time. According to the police report, he was arrested at his home after he pushed his wife and another individual when they attempted to perform an intervention for his alcohol and drug abuse. Police struggled with him and he was tazed and handcuffed. Dr. Grade had 4 oz of Brandy during the day and possibly Oxycontin.

Board Staff scheduled an interview to meet with Dr. Grade; however, he did not appear. When he later contacted Staff he stated that he was unable to retrieve his mail from his home as there was a restraining order issued and that he was in northern Arizona living out of his car. Dr. Grade claimed his arrest did not involve alcohol and he was not going to undergo the evaluation ordered by the Board and stated he did not care if he ever practiced medicine in Arizona again. Staff was able to contact Dr. Grade by telephone on May 17, 2007. Throughout the conversation he was very difficult to understand and his voice was slurred. He stated he suffered a heart attack two weeks ago when he was tazed in lock-up. In addition, he informed Staff he was scheduled for an angiogram on Monday, May 21, 2007 and he is currently very sick. Patrick N. Connell, M.D., stated that from the evidence

presented, Dr. Grade appears to have serious psychiatric problems and clearly represents an imminent threat to the public and himself. Dr. Connell felt the Board had no choice but to summarily suspend Dr. Grade's license.

MOTION: Patrick N. Connell, M.D. moved to summarily suspend the physician's license based on an imminent threat to public health and safety.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.
Absent: Dan Eckstrom, Douglas D. Lee, M.D., and Lorraine L. Mackstaller, M.D.
VOTE: 9-yay, 0-nay, 0-abstain, 3-absent, 0-recuse.
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0471A	P.P.	RAJIV M. ASHAR, M.D.	26872	Issue an Advisory Letter for an inadequate medical record and failing to notify the Board of a change of address in a timely fashion. The matter does not rise to the level of discipline.

Rajiv M. Ashar, M.D. was present with counsel, Ms. Judith Berman. Kelly Sems, M.D., Medical Consultant, summarized the case for the Board. Staff found that Dr. Ashar failed to properly diagnose, failed to provide adequate follow up care and charged for services not rendered. Also, during the course of the investigation Dr. Ashar failed to provide requested documents to the Board in a timely manner. Dr. Ashar apologized to the Board for the delay in responding to this complaint. When he made the transition form his previous job to private practice, this was one of the important things he missed on his checklist. He felt the care and treatment he provided to this patient was adequate.

Lorraine Mackstaller, M.D., led the questioning. Dr. Ashar confirmed he is a Board Certified Cardiologist. Dr. Mackstaller was concerned with the adequacy of the history Dr. Ashar obtained on this patient. The patient's husband, a physician, stated that Dr. Ashar did not perform a physical examination on the patient. Dr. Ashar stated that the husband must have the dates confused and that when the patient first presented to him, he performed a physical examination. The husband was referring to the date she had a stress test done, at which time Dr. Ashar did not perform a physical examination. Dr. Ashar has since changed his practice and his attitude is that the patient is always number one. He stated this was the first time he has ever been accused of not performing a physical examination on a patient. In addition, he stated he is now aware of notification requirements and the legal aspects of practicing medicine.

Paul M. Petelin, Sr., M.D., was concerned with the discrepancy of the patient's complaint and the documentation in Dr. Ashar's record. Dr. Ashar stated he used a template record for congestive heart failure that contained a list of symptoms and checked the boxes on the template. This template automatically assumes that he has asked the right questions. Robert P. Goldfarb, M.D. asked Dr. Ashar for clarification regarding his billing records. Dr. Ashar used billing codes that indicated he was hands-on with the patient. On one occasion he billed for a hands-on appointment when he supervised his technician who performed a stress test on the patient.

In closing, Ms. Berman pointed out that that Dr. Ashar's failure to notify the Board of a change of address should only initiate a fine and is not automatically a finding of unprofessional conduct. She stated that Dr. Ashar was given a week to respond to the complaint after being called regarding the investigation, but did not meet that deadline. Vicki Johansen, Case Manager, stated that the delay in obtaining a response to the complaint from Dr. Ashar was not only due to his failure to notify the Board of a change of address. She stated several attempts were made on behalf of Staff to obtain his response, but Dr. Ashar did not meet any of the three deadlines. Dr. Mackstaller noted Dr. Ashar's failure to respond to the Board in a timely manner and also felt that his records were inconsistent due to his use of a template.

MOTION: Lorraine Mackstaller, M.D. moved to issue the physician an Advisory Letter for an inadequate medical record and failing to notify the Board of a change of address in a timely fashion. The matter does not rise to the level of discipline because the record was based on a template.
SECONDED: Patricia Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Member was against the motion: Paul M. Petelin, Sr., M.D.

VOTE: 8-yay, 1-nay, 0-abstain, 3-absent, 0-recuse.
MOTION PASSED.

Robert P. Goldfarb, M.D. hoped the physician would take into consideration that the Board had given him the benefit of the doubt. However, he was troubled by Dr. Ashar's recordkeeping.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0340A	C.T.	RENE A. LUCAS, M.D.	19775	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to recognize addictive behavior, for failing to obtain medical records of prior treating physicians, for prescribing Duragesic patches in a manner that circumvented the rules for prescribing and that was equivalent to pre-dating, and for signing an undated prescription.

Rene A. Lucas, M.D., was present with counsel, Mr. Daniel P. Jantsch. Drs. Krishna and Petelin both stated that they knew Mr. Jantsch, but it would not affect their ability to adjudicate this case. Carol Peairs, M.D., Medical Consultant, summarized the case for the Board. Staff found that Dr. Lucas failed to contact patient FT's current prescribing pain specialist or obtain medical records prior to prescribing pain medication to FT. The standard of care requires a physician to review pertinent medical records. If the decision is made to prescribe long term opioids, the standard of care requires verification of current dosages and appropriate monitoring of the response in terms of the function, pain, side effects, and abuse. Dr. Lucas deviated from the standard of care by failing to recognize addictive behavior and failing to obtain medical records from previous treating physicians. Dr. Lucas stated when FT he first presented to him he claimed he was on multiple pain medications and was seeing a pain specialist. FT wanted Dr. Lucas to continue prescribing to him since he was having difficulty traveling to Scottsdale, Arizona to see his pain management specialist. Dr. Lucas agreed to continue prescribing to him with the intent to obtain the proper pain management treatment. Dr. Lucas' goal was to decrease FT's pain until he could refer him to a pain clinic.

Ram R. Krishna, M.D., led the questioning. Dr. Lucas briefly informed the Board of his medical background and training. Dr. Lucas stated he did not have access to FT's medical record until one month after FT first presented to him. Dr. Lucas acted as FT's pain management specialist, but does not refer to himself this way. Dr. Lucas was not aware of the Board's pain management guidelines at the time of this incident. Dr. Lucas realized that FT needed to be placed in an inpatient setting for detoxification because he was difficult to manage. Dr. Krishna noted seven month intervals in which Dr. Lucas would prescribe to FT without physically seeing him. According to Dr. Lucas, he had his Medical Assistant write the prescription and he would sign it. Dr. Lucas claimed she failed to advise him of the timeframes. Dr. Lucas no longer employs the medical assistant. Dr. Lucas also stated that his current practice consists of about one thousand patients and he has instituted all of the Board's pain management guidelines.

Robert P. Goldfarb, M.D., stated that Dr. Lucas was reinstituting pain medication to FT after Wayne State University recommended alternative ways to deal with his pain and suggested trying to get him off the pain medication and that Dr. Lucas did not enter a pain management contract with FT. Dr. Lucas stated when he treated FT he did not know he was required to enter such a contract, but is aware now. Dona Pardo, Ph.D., R.N. noted that Dr. Lucas stated in his current practice he does not see chronic pain patients who require narcotics. Dr. Lucas stated that his goal was to get the patient into another pain management clinic that would be more effective. Dr. Lucas took full responsibility for his office and their actions and stated that the patient had real pain and he tried to get him the help he needed. In closing, Mr. Jantsch asked the Board to take into consideration that this was a very difficult and complex patient. Unfortunately, Dr. Lucas found himself trying to help him and was a little out of his realm. His care was certainly not optimal, but this was a type of patient that a physician cannot just apply a "cook book" to. Dr. Krishna said Dr. Lucas recognized his mistakes; however, there was patient harm when he did not have access to his records prior to providing prescriptions.

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(k)- Signing a blank, undated or predated prescription form, A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public, and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

MOTION: Ram R. Krishna, M.D. moved for Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to recognize addictive behavior, for failing to obtain medical records of prior treating physicians, for prescribing Duragesic patches in a manner that circumvented the rules for prescribing and that was equivalent to pre-dating, and for signing an undated prescription.

SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D. William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0208A	AMB	FRANCIS M. PRICE, M.D.	17392	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for making a false statement to the Board, specifically for failing to state he was arrested for DUI in 1993 and for failure to report, as required, his DUI arrest of August 14, 2005 and subsequent conviction.

Francis M. Price, M.D. was present without counsel. Vicki Johansen, Case Manager, summarized the case for the Board. Dr. Price did not report his driving under intoxication (DUI) arrest within ten days as required by statute and the Phoenix City Prosecutor notified the Board after proceedings took place. During an interview with Michel Sucher, M.D., the Board's Addiction Medicine Consultant Dr. Price denied any other DUI. As a result, Dr. Sucher thought this was an isolated incident of alcohol abuse. When later confronted by evidence of a prior DUI, Dr. Price admitted he had another DUI arrest. Dr. Price maintained he did not tell Dr. Sucher about the previous arrest because the charge was thrown out due to lack of information. Staff found that Dr. Price failed to report his arrest. In June 2006, Dr. Price entered into an Interim Practice Restriction.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted that Dr. Price is not practicing medicine due to medical reasons and does not anticipate returning to practice in Arizona. Dr. Price admitted that it was a bad choice when he initially denied any DUI arrest, but then admitted to the 1993 arrest. He thought that the charges being dropped for lack of evidence meant he did not have to report the arrest, but still stated that it was a bad choice. Following that arrest, he was cited but never lost his driver's license. As he recalled, the charges were dropped due to problems with the breathalyzer test. He was arrested again on August 14, 2005 and was ultimately convicted in February of 2006. He was not aware he was required to report his arrest to the Board. Dr. Connell believed that Dr. Price has admitted he violated statutes A.R.S. §32-1401 (27)(a)- Violating any federal or state laws or rules and regulations applicable to the practice of medicine, specifically A.R.S. § 32-3208; and A.R.S. §32-1401 (27)(jj) - Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the Board. Dr. Connell felt it mitigating that Dr. Price admitted he made a bad choice and for medical reasons he does not anticipate returning to practice.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(a)- Violating any federal or state laws or rules and regulations applicable to the practice of medicine, specifically A.R.S. § 32-3208; A.R.S. §32-1401 (27)(jj) - Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board, and A.R.S. §32-1401 (27)(dd)- Failing to furnish information in a timely manner to the board or the board's investigators or representatives if legally requested by the board.
SECONDED: Germaine Proulx
VOTE: 10-yay, 0-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved for a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for making a false statement to the Board, specifically for failing to state he was arrested for DUI in 1993 and for failure to report, as required, his DUI arrest of August 14, 2005 and subsequent conviction.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0062A	AMB	STEPHEN P. SUTTON, M.D.	28812	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to appropriately treat a pseudomonas infection of the urinary tract, for failing to perform a nephrectomy and failing to discuss all the alternatives with a patient.

Stephen P. Sutton, M.D., was present without counsel. William Wolf, M.D., Medical Consultant, summarized the case for the Board. This case stemmed from two malpractice cases. In the first case, Dr. Sutton deviated from the standard of care by not providing patient JS with the appropriate antibiotics. Dr. Sutton stated his care was appropriate and JS had been noncompliant. Dr. Sutton was out of town when JS's second culture was received, which is why he did not act upon it immediately. Dr. Sutton reiterated his medical plan was sound.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Sutton confirmed he currently practices as an Urologist in Ohio and the Ohio Medical Board did not take any action against his license due to the malpractice case. The Ohio Medical Board does not take any action until a physician has three malpractice cases. Dr. Sutton stated that JS was compliant a week later then ordered and was immediately referred to a family practice physician. Dr. Sutton stated that if he could have done anything different, he would have been more aggressive in JS's care and treatment. He has since implemented a new system in the office and is more proactive in calling patients to schedule return appointments. His office also send letters to the patients if need be.

Dr. Wolf briefly summarized the second malpractice case for the Board. This case involved patient HS and Dr. Sutton deviated from the standard of care by not providing adequate information regarding the diagnosis and treatment. Dr. Sutton disagreed with the Board's findings in this case. He agreed that he erred by not fully documenting his discussion with HS, but maintained he was correct by not removing the kidney. Dr. Sutton discussed with HS the risks of doing nothing and that the kidney was still functioning well enough. Dr. Sutton has made improvements in his practice, but does not regret trying to save her kidney. Dr. Petelin noted a fairly large stone volume in HS's kidney; that the medical record failed to document any discussion of possible nephrectomy, and he still only performed non-nephrectomy treatments. Dr. Petelin felt damage was done as a result of the inappropriate antibiotics and that nephrectomy should have been offered. The standard of care requires nephrectomy in a poorly functioning kidney. Dr. Sutton fell below the standard of care by not recommending and performing surgery in a timely manner. William R. Martin, III, M.D., Chair, recommended addressing the issue of unprofessional conduct regarding patients JS and HS separately.

MOTION: Paul M. Petelin, Sr., M.D. moved for a finding of unprofessional conduct, for the case involving patient JS, in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patricia Griffen
VOTE: 6-yay, 1-nay, 3-abstain, 2-absent, 0-recuse.
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., M.D. moved for a finding of unprofessional conduct, for the case involving patient HS, in violation of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Patricia Griffen

Ram R. Krishna, M.D. spoke against the motion. Dr. Krishna stated it was difficult for him to determine if the procedure performed was incorrect. Dr. Krishna felt the documentation was an issue and did find that Dr. Sutton committed unprofessional conduct in that matter, but not in regard to the procedure performed. Dr. Petelin stated that what disturbed him was the large volume of stone in the kidney that would have to be eradicated in order to try to save any function of the kidney.

Dr. Martin agreed with both Drs. Krishna and Petelin. His tendency is to take into account the entire clinical situation. However, he stated that in this patient's case the clinical judgment should have been to perform a nephrectomy. Dr. Martin stated Dr. Sutton admitted that his recordkeeping was poor.
VOTE: 6-yay, 1-nay, 3-abstain, 2-absent, 0-recuse.
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., M.D. moved for a Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to appropriately treat a pseudomonas infection of the urinary tract in JS, for failing to perform a nephrectomy, and failing to discuss all the alternatives with patient HS.
SECONDED: Patrick N. Connell, M.D.

Dr. Petelin stated that a Letter of Reprimand was appropriate in this case due to the actual and potential harm identified.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia Griffen, William R. Martin, III, M.D., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Member were against the motion: Lorraine Mackstaller, M.D.
VOTE: 6-yay, 1-nay, 3-abstain, 2-absent, 0-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-1068A	AMB	CHARLES A. BOLLMANN, M.D.	6020	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate care, inadequate records, inadequate supervision, inappropriate billing and making false statements. Two Years Probation to include random chart reviews.

Charles A. Bollmann, M.D. was present with counsel, Ms. Robin E. Burgess. William Wolf, M.D., Medical Consultant, summarized the case for the Board. This case came before the Board as a result of a medical malpractice settlement. Staff found Dr. Bollmann deviated from the standard of care by not recording an adequate history and physical. Patient CH obtained second degree burns as a result of the laser treatment she received from Dr. Bollmann's office. Tina Geiser, Case Manager, stated that Dr. Bollmann committed unprofessional conduct by obtaining a fee by fraud or misrepresentation and allowing unlicensed individuals from his office staff to perform laser hair removal procedures on his patients.

Dr. Bollmann stated that the laser hair removal procedure has been performed in health spas across the country by unlicensed individuals and that regulations at that time did not require the laser technician to be licensed and did not require any physician involvement. He stated; however, he was in the office at the time of the treatments, was in the room for one, approved the treatments and felt the treatment provided was sufficient. He noted that current regulations state that a physician only needs to be immediately available during this type of treatment. He stated he was not trying to deceive anyone with the operative report he provided to the insurance company for billing. The report was provided at the request of CH's mother. Dr. Bollmann generated the report indicating he performed the procedure. However, Dr. Bollmann admitted the laser technician had performed the procedure. He did not feel it was wrong that he signed the report as if he performed the surgery.

William R. Martin, III, M.D. led the questioning. Dr. Bollmann was initially trained to perform a history and physical examination on every patient. Dr. Bollmann felt it was not necessary to perform a history and physical examination for laser hair removal treatments; however, he billed CH's insurance company for a history and physical examination. During the course of the investigation, Board Staff attempted to obtain CH's medical records from Dr. Bollmann. Dr. Bollmann provided a response stating his previous attorney had destroyed the records after the malpractice settlement as he did not think he would need them again. Dr. Bollmann admitted that he violated the law by not keeping CH's medical records for the required retention period.

Paul M. Petelin, Sr., M.D. noted that Dr. Bollmann used the diagnosis of CH's dermatologist when billing the insurance company instead of developing his own findings and diagnosis. He stated the attending surgeon needs to be present for the certain phases of the operation. If Dr. Bollmann billed, but was not there for the critical part of the operation, that is considered to be fraud. Robert P. Goldfarb, M.D., informed Dr. Bollmann that the purpose for a postoperative report is to document the procedure performed and the findings so another healthcare provider is aware of what was done. Dr. Goldfarb asked how Dr. Bollmann would know the specifics of the procedure if he was not present. Dr. Bollmann agreed that this was not acceptable. Patrick N. Connell, M.D. noted Dr. Bollmann stated the laser was at the same setting for each of CH's visits. However the medical records describe four different dosages. Dr. Bollmann said CH received the burns because she tanned over the summer, despite her claims that she did not. In closing, Ms. Burgess stated that CH was very adamant that she wanted the laser treatment. She informed the Board that CH was also seeking treatment at other facilities, as well as Dr. Bollmann's office.

Dr. Martin found that the records were unclear and Dr. Bollmann did not meet the standard of care in many different areas. The false medical records were created specifically to deceive the insurance company. The standard of care requires a physician to obtain a history and physical examination. Dr. Martin noted that consent was obtained but believed that the standard of care clearly requires that a physician adequately supervise the technician. In terms of billing, if Dr. Bollmann submitted that he performed a procedure, he should have done the procedure or been present.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public., A.R.S. §32-1401 (27)(t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution, and A.R.S. §32-1401 (27)(v) Obtaining a fee by fraud, deceit or misrepresentation.
SECONDED: Paul M. Petelin, Sr., M.D.

VOTE: 10-yay, 0-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

Dr. Martin noted there were previous Board actions for similar offenses and Dr. Bollman clearly has not and is not keeping adequate records on patients and has admitted that he has not kept records according to the retention period as required by statute.

MOTION: William R. Martin, III, M.D. moved for Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate care, inadequate records, inadequate supervision, inappropriate billing and making false statements. Two Year Probation to include random chart reviews.
SECONDED: Ram R. Krishna, M.D.

Dr. Petelin spoke in favor of the motion and felt these were egregious ethical violations. Dr. Martin said that the physician showed no compassion during his interview and no remorse for the patient. Dr. Bollmann has been issued two Letters of Reprimand in the past including CME in ethics and did not get the message. In addition, the interview indicates the Board should be monitoring Dr. Bollmann.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-06-0513B	I.R.	JOHN P. WOHLER, M.D	25661	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to perform an adequate neurological examination, failure to properly address neurologic complaints and symptoms in a patient with gliomatosis cerebri and failure to arrange for appropriate emergency intervention. One Year Probation to include 20 hours of CME in the diagnosis of intracranial lesions, such as tumors and hemorrhages. Probation to terminate upon completion of CME.

IR addressed the Board during the call to the public. She was glad to represent her husband, patient RR. She hoped to gain justice and wanted to make sure what happened to them never happens to anyone else. She stated that Dr. Wohler failed to appropriately evaluate RR and he did not have any control over his healthcare needs. She opined that Dr. Wohler's negligent care was inhumane and she felt her husband may have lived if he would have received proper treatment.

Dr. Wohler was present with counsel, Mr. Byrl R. Lane. Kelly Sems, M.D., Medical Consultant, summarized the case for the Board. Staff found that Dr. Wohler failed to adequately perform a neurological exam. Robert P. Goldfarb, M.D. led the questioning. Dr. Wohler works full time in the prison system and is a Board certified family practitioner. He has worked in the prison system for seven years at multiple facilities and was at a different location when RR's care began. RR had a diagnosis from his primary physician of vascular headaches; Dr. Wohler thought the headaches were stress induced. Dr. Wohler gave RR medication to get him through the night and to lower his blood pressure and stated if his symptoms had remained the same in the morning, Dr. Wohler would have had reason to move him to an acute care facility. Dr. Wohler did not feel it was urgent to obtain the brain imaging ordered by another physician and thought it could wait a few more days. Dr. Wohler stated that the pattern of RR's pain was not suggestive of increased intracranial pressure. Dr. Wohler said it was in the patient's best interest to take pain medication throughout the night and then transfer him to the hospital in the morning. Transferring patients at night requires transporting by helicopter and he felt that it may be too uncomfortable for him.

Ram R. Krishna, M.D. asked what Dr. Wohler would do if he were presented with the same situation if in a private practice. Dr. Wohler stated he would have given him the order to for a CT scan and he would have scheduled it within a reasonable timeframe. Dr. Wohler stated he would have sent RR for emergency treatment if there had been changes in his ocular findings. In closing, Mr. Lane stated that the Board should be aware in reviewing the medical chart that a number of health care providers saw this particular patient and there was no documentation of neurological deficit that was of an emergent nature.

Dr. Goldfarb said this was a difficult case since it occurred in a difficult environment, however, this did not mean that when working at this type of institution a physician does not need to follow the standard of care. Dr. Goldfarb felt that the institutional aspects were mitigating in this case, but stated that Dr. Wohler fell below the standard of care for his failure to recognize and properly

assess the patient. Dr. Goldfarb noted RR's condition was so advanced his outcome would not have changed even if there had been earlier intervention.

MOTION: Robert P. Goldfarb, M.D., moved for a finding of Unprofessional Conduct moved for a finding of A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 9-yay, 0-nay, 1-abstain, 2-absent, 0-recuse.
MOTION PASSED.

MOTION: Robert P. Goldfarb, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to perform an adequate neurological examination, failure to properly address neurologic complaints and symptoms in a patient with gliomatosis cerebri and for arrange for appropriate emergency intervention. One Year Probation to include 20 hours of Continuing Medical Education (CME) in the diagnosis of intracranial lesions, such as tumors and hemorrhages. Probation to terminate upon completion of CME.
SECONDED: Patrick N. Connell, M.D.

Lorraine Mackstaller, M.D. was saddened that the patient had complained of symptoms for approximately two months prior. She thought that there were some mistakes made by other physicians and not only by Dr. Wohler. Dr. Connell stated that he realized the prison is a difficult environment in which to work and prisoners are difficult to treat, but noted that the Board has repeatedly seen problems in the prison medical system where patients have acute problems that are not addressed. The patients are transferred from one provider to another over a period of time and the problems are never addressed. Providers in the prison system need to take a stand and say "no". If the physician is not provided with a mechanism to appropriately refer a patient when need be, it is up to the licensee to attempt to do something about that either individually or within a group. William R. Martin, III, M.D. spoke in favor of the motion. Dr. Martin believed that a patient, whether he is in urban Phoenix, rural Globe or in the prison system deserves the bare minimum of the standard of care. He also believes that there were cardinal signs that were missed in this patient's case that, in any setting, should have been recognized, treated and acted upon. Dr. Martin was concerned that Dr. Wohler, when describing what he would have done in a private practice setting, still would not have referred the patient to the hospital immediately. Dr. Mackstaller was concerned that the situation was not even recognized as being emergent.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Germaine Proulx, and Amy J. Schneider, M.D. The following Board Member abstained: Paul M. Petelin, Sr., M.D.
VOTE: 9-yay, 0-nay, 1-abstain, 2-absent, 0-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0510A	A.A.	PAUL D. KAESTNER, M.D.	17448	Issue an Advisory Letter for failing to perform a physical examination prior to prescribing Viagra and Cialis.

D.D. spoke during the call to the public in support of Dr. Kaestner. He stated that from his experience and observation the treatment he and his family have received from Dr. Kaestner is well above the standard. In addition, he stated Dr. Kaestner was willing to review his medical records to determine the proper course of treatment when other treating physicians failed to determine the cause of his headaches. He believes Dr. Kaestner is an excellent physician. Paul D. Kaestner, M.D. was present with counsel, Michael Walz. Kelly Sems, M.D., Medical Consultant, summarized the case for the Board. It was alleged that Dr. Kaestner over-prescribed Cialis and Viagra to patient KD. Board Staff conducted a random chart review of five additional charts and found that Dr. Kaestner kept inadequate medical records and there was a boundary violation in a single patient.

Dr. Kaestner stated he went into private practice after seeing a need and feels patients are very comfortable with him. He stated It was easy for him to treat erectile dysfunction (ED) when Viagra came out due his background in sexually transmitted diseases and that he considers himself an expert in treating ED. Physical exams are offered to all patients and he recommends they maintain routine primary care. Ram R. Krishna, M.D. led the questioning. Dr. Krishna noted that Dr. Kaestner works out of his home on a "cash only" basis and, although he keeps patient records, there was no mention in his charts of having ordered lab tests. Dr. Kaestner stated that if a patient refuses a physical examination, he does not require one and continues to treat them if he feels the medication is safe and there are no contraindications in the medical history. If they are at risk of serious medical problems he recommends they seek further medical treatment. Dr. Krishna noted that one of the patients in question was a Methadone addict to whom Dr. Kaestner had loaned money for an abortion. Dr. Kaestner stated that he felt this patient was in no way motivated to stop taking narcotics and felt this was in the patient's best interest. Dr. Kaestner discussed the incident when he prescribed forty prescriptions to a patient within a 30-day period. The pharmacist was concerned and declined to fill the prescription and the patient called Dr. Kaestner. He told the patient that this must have been a computer error and advised them

to go to another pharmacy as he believed the patient's story that there was a problem at the pharmacy. Even though it may appear to the Board that this was wrong, he did not agree.

Paul M. Petelin, Sr., M.D. opined that Dr. Kaestner has an unorthodox practice style. He was concerned that in practicing from his home in a solo manner and performing exams with female patients that he is exposing himself to potential liability by not having a chaperone present. Dr. Kaestner stated that he informs the patients that he works alone, from his home, and recommends that patients bring their own chaperone. He does not believe patients threaten physicians who treat them kindly and appropriately. Dr. Kaestner sees approximately eight to ten patients at his home on busy days. He sees usually four on days that are fairly slow and charges $150.00 for a standard visit. He stated he has treated patients for less when he feels patients are unable to pay the full amount. In addition, Dr. Kaestner stated he rarely prescribes pain medications. In closing, Mr. Walz stated Dr. Kaestner is a great physician. He stated there is nothing to indicate that Dr. Kaestner did anything wrong. The methamphetamine addict was extremely difficult patient to deal with, much less get her to do something in her best interest. Dr. Krishna stated that Dr. Kaestner might be a caring physician, but the basic treatment involves performing a physical examination. A physical examination is necessary since a physician cannot just take the word of the patient, because there are a lot of patients who know they can procure medication through a well meaning physician by giving a good history and then trying to obtain the medications. Dr. Krishna noted that Dr. Kaestner agreed his medical recordkeeping is poor.

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient, and A.R.S. §32-1401 (27)(q) - Any conduct that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Patrick N. Connell, M.D.
VOTE: 8-yay, 2-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED

MOTION: Ram R. Krishna, M.D., Letter of Reprimand for inadequate evaluation of three patients prior to prescribing erectile dysfunction medication, excessive prescribing of erectile dysfunction medication for one patient and a boundary violation for another patient.
This motion was not seconded and therefore failed.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for failing to perform a physical exam prior to prescribing Viagra and Cialis.
SECONDED: Patrick N. Connell, M.D.

Dona Pardo, Ph.D., R.N. stated that her main concern was the boundary violation from a professional point of view; however, she was also concerned with the lack of physical examinations as well.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., and Amy J. Schneider, M.D. The following Board Members voted against the motion: Ram R. Krishna, M.D. and Germaine Proulx.
VOTE: 8-yay, 2-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-0493A	J.W	JAY S. NEMIRO, M.D.	12781	Issue an Advisory Letter for failure to document discussion regarding ZIFT versus IVF when providing informed consent. There is insufficient evidence to support discipline.

Jay S. Nemiro, M.D. was present with counsel, Randy Yavitz. Robert P. Goldfarb, M.D. stated he had a professional relationship with Mr. Yavitz, but it would not affect his ability to adjudicate the case. William Wolf, M.D., Medical Consultant, summarized the case for the Board. Staff found no indication in the medical record that the patient was offered in vitro fertilization (IVF) versus the zygote intrafallopian transfer (ZIFT) procedure, raising issues of informed consent. Dr. Nemiro stated he fully acknowledges the documentation issue and took full responsibility for the lack of documentation. He stated that since his meeting with the Board last year, he has implemented a full documentation process.

Amy J. Schneider, M.D., led the questioning. Dr. Nemiro confirmed his current practice is solely the treatment of infertility and approximately seventy five percent of his practice consists of performing the ZIFT procedure. Dr. Schneider noted the patient five years ago underwent a study on the Hysterosalpingogram (HSG) test that indicated her tubes were blocked and was diagnosed with endometriosis. Dr. Nemiro stated he treated this couple for infertility caused by the husband's vasectomy and had nothing to

do with her prior treatment, although she did not tell him about the prior treatment. He stated in his experience, HSG tests are wrong 23 percent of the time and this patient was a perfect example of that.

Dr. Nemiro did not comment on any finding of endometriosis or any lack thereof. Dr. Nemiro stated that last year, his practice had a zero complication rate performing the ZIFT procedure and he has no financial interest in either procedure. Dr. Goldfarb wondered why IVF was not successful in Dr. Nemiro's practice as it is throughout the rest of the country. Dr. Nemiro stated his practice tends experience better results with the ZIFT procedure and patients are offered a choice. Paul M. Petelin, Sr., M.D. noted that there are a certain number of zygotes that he should transfer according to the standard of care. Dr. Nemiro stated he had transferred about five in this case and has religiously followed the established guidelines.

In closing, Mr. Yavitz informed the Board this patient was told by other specialists there was no chance of her having children. She went to Dr. Nemiro and chose the ZIFT procedure and miraculously became pregnant and another patient had five children from using the ZIFT procedure. He stated Dr. Nemiro had been practicing for 24 years with thousands of live births and has had a great deal of success. He also stated Dr. Nemiro acknowledges and takes full responsibility for the documentation issues.

Dr. Schneider said that this did not rise to unprofessional conduct nor did it rise to the level of discipline.

MOTION: Amy J. Schneider, M.D. moved to issue an Advisory Letter for failure to document discussion regarding ZIFT versus IVF when providing informed consent. There is insufficient evidence to support discipline.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D., R.N., Paul M. Petelin, Sr., M.D., Germaine Proulx, and Amy J. Schneider, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-absent, 0-recuse.
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-06-0500A	AMB	KAREN A. CLARK, M.D.	32348	Dismiss.

Karen A. Clark, M.D. was present with counsel, Mr. Steve Myers. Drs. Mackstaller and Pardo both stated that they knew the nurse practitioner involved in this case, but it would not affect their ability to adjudicate the case. Kelly Sems, M.D., Medical Consultant, summarized the case for the Board. The complaint alleged Dr. Clark failed to provide appropriate medical care to patient EM. Dr. Clark stated she was involved in EM's care postoperatively as a closure device had not been used and the sheath was left in the patient. She stated EM was improving overnight so she decided not to take emergent action. Dr. Clark has tried to think of ways that she might have been able to save the patient's life and has learned from this case and does not hesitate to order imaging studies.

Lorraine Mackstaller, M.D. led the questioning. Dr. Clark opted to have her colleague, a cardiologist, assume care for this patient as she was convinced that EM was a drug seeking patient and felt uncomfortable proceeding. Yet Dr. Clark was given responsibility for EM's postoperative care. She was called twice throughout the night by the nurses monitoring EM. When she was called, she was informed that EM's blood pressure had dropped and she was hanging off of her bed with her pain medication in her hand. Dr. Clark was not aware of how EM had gotten the pills. Dr. Clark attended to the patient by removing the sheath and applying pressure and the patient began to stabilize. Paul M. Petelin, Sr., M.D. noted apparent friction between Dr. Clark and her partner, the cardiologist and also noted Dr. Clark did not know she would be covering for him that night. Dr. Clark stated that when covering for the cardiologist, he did not inform her of the patient's status and does not routinely transfer patients. Dr. Clark is no longer employed at the practice. Robert P. Goldfarb, M.D. noted when Dr. Clark called the cardiologist, he told her it was just a small bleed and to remove the sheath. In closing, Mr. Myers noted in this case, the sheath had not been removed and a closure device had not been used. He stated that once the sheath was removed and pressure had been applied, there was no reason to suspect a retroperitoneal bleed. Dr. Clark had her own appointment for surgery the next morning and upon leaving the recovery room, Dr. Clark kept asking about her patient and insisted on being bedside with the patient and her family while she herself was in a wheelchair.

Dr. Mackstaller noted Dr. Clark was never told about the complications of the stick of the extravasations and was not scheduled to be on-call that evening. Dr. Mackstaller believed that Dr. Clark considered the bleed and acted appropriately and could not find her at fault.

MOTION: Ram R. Krishna, M.D. moved for dismissal.
SECONDED: Lorraine Mackstaller, M.D.

Dr. Petelin spoke against the motion for dismissal. He felt Dr. Clark made an error in judgment by failing to obtain a timely surgical consultation. Dr. Petelin stated he would be more in favor of an Advisory Letter. Dr. Goldfarb agreed with Dr. Petelin and felt she should be issued an Advisory Letter adding that even though she is a caring physician, she unfortunately did not handle the problem appropriately. Dr. Mackstaller felt Dr. Clark did handle the problem appropriately by following the treatment and noted the patient was stable. Dr. Krishna agreed it was handled properly as there was constant bleeding and said she deserved credit for how she handled the situation. He also noted the cardiologist failed to inform her of the complications of the procedure.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., and Germaine Proulx. The following Board Members were against the motion: Paul M. Petelin, Sr., M.D. and Amy J. Schneider, M.D. The following Board Members abstained: Robert P. Goldfarb, M.D., William R. Martin, III, M.D., and Dona Pardo, Ph.D., R.N.
VOTE: 5-yay, 2-nay, 3-abstain, 2-absent, 0-recuse.
MOTION PASSED.

The meeting adjourned at 6:15 p.m.

Timothy C. Miller, J.D., Executive Director